<div style="border:1px solid">

REQUEST FOR

INDEPENDENT EVALUATION

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Student:_____ Birthdate:_____
          last   first   m.i.   mm dd yy

Grade/Level:_____ Attendance Center:_____ District: _____

Parent(s) or Guardian (including first and last names):_____

Address: _____ Telephone: _____
          number   street

_____
          city   state   zip

REASON FOR REFERRAL

List reason(s) why an Independent Educational Evaluation is requested. What questions need to be answered in order to further plan appropriate educational interventions for this individual? If space is not sufficient, attach additional questions to this form:

_____

_____

_____

_____

Request referral to (specify name and address):   Central Rivers AEA staff members requesting this service:

_____   Name:_____

_____   _____

_____   Date:_____ Position:_____
                                        mm dd yy

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I grant permission to have my child evaluated for the reason(s) stated above. This service is to be performed by the agency specified. I also grant permission for my child's school records to be shared with authorized staff of the outside evaluator/provider.

Date:_____   Signature:_____

If signed by any person other than the student, state relationship:_____

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EXPENDITURE APPROVAL

If signed below, approval* has been granted for this request. The provider may invoice evaluative cost as appropriate, however, the predetermination inquiry limits* amount to no more than $_____ Additionally, parent(s) may claim direct reimbursement from AEA as follows:

Travel (will need an odometer report for miles traveled)_____ $_____ (estimated)

Food/Lodging (parent/student only – receipts required) _____ $_____ (estimated)

NOTE: This approval of expenditures does **NOT** include cross-referral, laboratory services, or other follow-up beyond the level of evaluation requested here. This request becomes null and void nine (9) months from the date of the Special Education Director's signature. Payment for services is contingent upon Central Rivers AEA receiving a report of the evaluation results and recommendations.

Date:_____ Signature:_____
      mm dd yy   AEA Special Education Administrator

Send invoice to: Central Rivers AEA Special Education Services, 1521 Technology Parkway, Cedar Falls, Iowa 50613

Copies: AEA, Resident LEA; Parent; Attending LEA (if different than Resident LEA)   (4/2017) Central Rivers AEA